2015 Open Enrollment Form – State of New Hampshire Employees

A

☐ New Enrollment (check all that apply)	☐ Waiving/Removing Coverage *(check all that apply)*	☐ Changing Plans *(check which applies)*	Employer Name and Address: **State of New Hampshire 28 School Street, Concord, NH 03301**	
☐ Newly Enrolling Self ☐ Newly Enrolling Spouse ☐ Newly Enrolling Child(ren) ☐ Enrolling in 2015 Medical FSA ☐ Enrolling in 2015 Dep Child Care FSA	☐ Waiving medical or dental for Self ☐ Removing coverage for Spouse ☐ Removing coverage for Child(ren)	☐ HMO to POS ☐ POS to HMO	Employee Social Security #: _____-_____-_____ NH FIRST Employee ID #: _____	Email Address: Work Phone: Home Phone:

B

Employee Name (PLEASE PRINT): First Name MI Last Name	Employee Date of Birth: *(mm/dd/yyyy)* _____/_____/_____
Mailing Address (PLEASE PRINT) City State Zip Code	

C

First Name MI Last Name	Add, Change or Waive/Remove	Date of Birth	Gender	Coverage Selection if Newly Adding	2015 Flexible Spending (FSA) Elections *(Choose one for Medical FSA and one for Dependent Child Care FSA)*
Employee **SAME AS ABOVE**	☐ Add or Change *(specify under Coverage Selection)* ☐ Waive Medical ☐ Waive Dental	**SAME AS ABOVE**	☐ M ☐ F	Dental ☐ Medical *(choose one)*: HMO ☐ or POS ☐	☐ Enroll in Medical FSA ($2500/year max) $_____ / Year OR ☐ Waive Medical FSA for 2015 ☐ Enroll in Dependent Child Care FSA ($5000/year max) $_____ / Year OR ☐ Waive Dependent Child Care FSA for 2015
Spouse First Name MI Last Name Name:_____ SSN: _____-_____-_____	☐ Add *(specify under Coverage Selection)* ☐ Remove Medical ☐ Remove Dental	Date of Birth ____/____/_____	☐ M ☐ F	☐ Dental ☐ Medical	If newly adding a spouse to your coverage, please attach marriage certificate for supporting documentation.
Child #1 First Name MI Last Name Name: _____ SSN: _____-_____-_____	☐ Add *(specify under Coverage Selection)* ☐ Remove Medical ☐ Remove Dental	Date of Birth ____/____/_____	☐ M ☐ F	☐ Dental ☐ Medical	If newly adding a child to your coverage, please attach birth certificate and additional supporting documentation (ie: adoption paperwork or court order), if applicable.
Child #2** First Name MI Last Name Name: _____ SSN: _____-_____-_____	☐ Add *(specify under Coverage Selection)* ☐ Remove Medical ☐ Remove Dental	Date of Birth ____/____/_____	☐ M ☐ F	☐ Dental ☐ Medical	If newly adding a child to your coverage, please attach birth certificate and additional supporting documentation (ie: adoption paperwork or court order), if applicable.

****Additional children should be listed on a second enrollment form.**

D

The information provided above is true and correct to the best of my knowledge. I also understand that the dependent coverage will not be effective until I provide appropriate documentation to my agency Human Resource office.

Employee Signature:_____ **Date:** _____/_____/_____

** **Please make a copy of this form for your personal records****

For Agency Benefit Representative Use Only	**Agency Name**	**Agency Benefit Representative Name**	**Contact #**	**Date Sent to DOP** *(if applicable)*	**Effective Date**
Payroll #: _ _ _ _					**1-1-2015**

Date NH FIRST Updated: _____ Initials: _____

Revised 10/4/14 - TH